misrepresent the reforms by making wild, speculative, and alarmist allegations. If scientific method is to be favoured I suggest that the *BMJ* runs a balanced series of articles about the reforms, allowing the many doctors in favour of the changes to discuss and debate them in a positive and constructive way, instead of providing only one, negative and defeatist side to this important argument.

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1 Smith T. Politicians and scientists. *Br Med J* 1990;**300**:1283-4. (19 May.)

SIR,—Dr Tony Smith asks whether someone on the bridge will slow, stop, or reverse our *Titanic*, the NHS, before it strikes the white paper iceberg.[1] If we cannot trust those on the bridge perhaps we should turn for help to the crew or the passengers, or both.

The crew can still determine its fate by ballot. Guy's Hospital managers conceded last year that they will not apply for the hospital to become self governing if a majority of consultants vote against the plan. Eastbourne Health Authority recently withdrew its expression of interest because of the result of a consultant ballot at its three hospitals. Colleagues throughout the United Kingdom are urged to express their opinion for or against self government before the NHS and Community Care Bill becomes law and others stand ready to make the decision for them.

The passengers should have their say, given that parliamentary representatives have taken scant notice of public opinion. Members of the public should join the NHS Support Federation to express their views and to protect and promote the NHS they want to see.[2] The "NHS Fed" is a broad alliance of those who work in and use the NHS. We will gladly supply information and application forms to anyone who wishes to join or help us recruit.

It is questionable whether firm action by crew and passengers could have saved the *Titanic*. It now seems certain that this is the only way to save the NHS.

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1 Smith T. Politicians and scientists. *Br Med J* 1990;**300**:1283-4. (19 May.)
2 Delamothe T. NHS Support Federation appealing for members. *Br Med J* 1990;**300**:216. (27 January.)

Perimenopausal women's views on hormone replacement therapy

SIR,—Our experience in general practice is similar to that described recently.[1,2] Since January 1988 we have offered to all of our 1200 female patients aged 40-60 a clinic for teaching about osteoporosis, hormone replacement therapy, and nutrition and for screening height, weight, blood pressure, smoking, and alcohol use and eligibility for hormone replacement therapy. Postal invitations describe the format of the clinic, which includes teaching from a doctor, a nurse, and a physiotherapist; video films; and a personal interview with the doctor.

Of those invited, 43% attended the clinic, and 45% of those who attended accepted a prescription for hormone replacement therapy. Thus a fifth accepted a prescription for hormone replacement therapy to prevent osteoporosis. There was a strong bias towards social classes I and II in the clinic attenders. This would probably have been even more marked if we had invited patients merely by displaying a poster in the waiting room.

Reasons given for refusing hormone replacement therapy included reluctance to have periods after the menopause and to medicalise life—"It's like taking an aspirin for a headache you haven't got."

A full description of this clinic and its audit will appear elsewhere.[3]

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2 Correspondence. Perimenopausal women's views on hormone replacement therapy. *Br Med J* 1990;**300**:1196. (5 May.)
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Health checks in general practice

SIR,—We congratulate Dr Deborah Waller and colleagues on their study,[1] the results of which confirm our subjective impressions of 12 years of serving a peripheral postwar council estate of 25 000 people (social classes III, IV, and V) and our early results of using the Oxford heart and stroke screening project.

Our experience suggested that to give high quality medical care incorporating health promotion, screening, and planned care programmes to social classes IV and V required an opportunistic model, with more doctor time in the consultation. Two years ago we decided to appoint an additional partner to improve our doctor:patient ratio from 1:1950 to 1:1560 and thus enable us to have at least 10 minute appointments despite the higher consultation rate of social classes IV and V. This concept was one of the main arguments we used in submitting our evidence and proposals to the local medical committee, family practitioner committee, and Medical Practices Committee. The need for this type of approach, with additional medical and nursing resources, for such socioeconomically deprived groups with high morbidity, high unemployment, poor housing, and high numbers of children under 5 has been recognised by Pill *et al*[2] and Marsh and Channing.[3]

Over the initial seven months (September 1989 to April 1990) that our health centre has been running the Oxford screening project a predictable pattern has emerged. Patients in the age range 35-64 attending the health centre are invited by the receptionists to book for a health screening check with our treatment room staff. Seven hundred and eighty five have been invited; of these, 409 made appointments, but only 311 came and were screened (40% of those invited). Of these, 110 (35%) were men, 114 (37%) were smokers, and 117 (38%) had cholesterol concentrations over 6·5 mmol/l. These results, early on, when uptake should be at its highest, show that Hart's inverse care law[4] does operate when attempts are made to apply a clinic model of care to the socioeconomically deprived.

Looking just at lifestyle issues without addressing socioeconomic and environmental factors is not enough. The factors influencing health and illness are more complex, and our patients know this. In Coulter's study, while the middle class identified lifestyle issues as the ones pivotal to their health, the working class groups identified socioeconomic and environmental inequalities.[5]

Health professionals must not allow the government to argue that good health is a personal and individual affair. Society, and the government representing it, has a responsibility to improve housing, reduce environmental pollution, increase low income, and improve working conditions. Many of the great health advances of the mid-nineteenth century were public health and social action issues, not the efforts of individuals or health professionals.

Resources need to be targeted appropriately, to our recognised and forgotten areas of deprivation,[6] if these communities are to have an average chance of health. The inverse care law urgently needs to be addressed.

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1 Waller D, Agass M, Mant D, Coulter A, Fuller A, Jones L. Health checks in general practice: another example of inverse care? *Br Med J* 1990;**300**:1115-8. (28 April.)
2 Pill R, French J, Harding K, Stott HCH. Invitation to attend a health check in a general practice setting: comparison of attenders and non-attenders. *J R Coll Gen Pract* 1988;**38**:53-6.
3 Marsh GN, Channing DM. Narrowing of the health gap between a deprived and an endowed community. *Br Med J* 1988;**296**:173-6.
4 Hart JT. The inverse care law. *Lancet* 1971;i:405-12.
5 Coulter A. Lifestyles and social class: implications for primary care. *J R Coll Gen Pract* 1987;**37**:533-6.
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Maternal and fetal screening

SIR,—We wish to comment on the suggestion by Dr M J V Bull that a comprehensive serum TORCH screen (toxoplasmosis, rubella, cytomegalovirus, herpes virus) may be appropriate before conception.[1] Dr Bull did not discuss the circumstances in which this might be appropriate or explore the implications of screening for these conditions before conception. The acronym may be a helpful aide memoire for a paediatrician faced with a sick neonate but is probably less useful to a general practitioner giving advice to a healthy woman.

Checking rubella antibody state before conception is desirable because those who are negative may be immunised and those who are positive may be reassured. The action to be taken in the light of the test result is clear, the possible benefits are considerable, and the risks are limited largely to the possibility of inappropriate reassurance to women who have false positive tests.

A test for antibodies to toxoplasmosis before conception is less easy to justify. Approximately 80% of women of childbearing age in the United Kingdom lack evidence of past infection with toxoplasmosis.[2] If the intention is to identify these women and advise them about ways of avoiding the infection extending the health education advice (which is not particularly restrictive) to all women would be a more efficient use of resources and would also protect those women who have false positive results of the screening test.

It is not clear what action should be taken or advice given after a preconception test for cytomegalovirus. About half the women who have the test will be told that they are susceptible to the virus and that there is no vaccine. Sexual transmission is well documented but the risks associated with close contact with babies and young children, much debated, are unknown—there is no consensus on specific advice about avoiding cytomegalovirus infection.[3] Fetal damage may occasionally follow reactivation of infection in pregnancy, as well as primary infection,[4] and thus reassurance for a woman with a positive test result may be inappropriate.

Screening for herpes virus is also complicated. Although primary infection in pregnancy is the main cause of fetal damage, serious damage may also follow recurrent infection. Probably only a few women who have had genital herpes will have had symptoms that led to diagnosis. Serological tests discriminating between antibodies to herpes simplex virus types 1 and 2 are not yet available routinely—even if they were a growing proportion of genital infections is now associated with type 1.[5] Only about 10% of women have no antibodies to herpes simplex viruses but probably 90% have not